

Initial Patient Sleep Screening Form

Patient Name:

Date:

EPWORTH SLEEPINESS SCALE: Please indicate how likely you are to doze off or fall asleep in the following situations:

O- NEVER 1- SLIGHT 2- MODERATE 3- HIGH CHANCE

Sitting and reading.....O 1 2 3

Watching Television.....O 1 2 3

Sitting in public place.....O 1 2 3

Passenger in a car for one hour.....O 1 2 3

Driving a car stopped for a few minutes in traffic.....O 1 2 3

Sitting & talking to someone.....O 1 2 3

Sitting down quietly after lunch without alcohol.....O 1 2 3

Lying down to rest in the afternoon.....O 1 2 3

Total Score: _____

PATIENT EVALUATION:

Bmi-(see attached chart) _____ Is it greater than or equal to 30? NO (0) YES (1)

Neck Circumference _____ Is it >17" (men) or > 15" (women) NO (0) Yes (1)

Have you gained at least 15 lbs. in the last 6 months? NO (0) Yes (1)

Total Score: _____

SUBJECTIVE SLEEP EVALUATION:

	No (0)	YES (1)
Do you snore?.....O	1	
You, or your spouse, would consider your snoring louder than a person talking.....O		1
Your snoring occurs almost every night?.....O		1
Your snoring is bothersome to your spouse?.....O		1
Do you feel that your sleep is not refreshing or restful? O	1	
Do you awake in AM with headaches?.....O		1
Do you experience fatigue during the day, have difficulty staying awake? O		1
Do you have trouble remembering things or paying attention? O	1	

Do you have high blood pressure?0 1

Total Score: _____

PRIOR DIAGNOSIS:

NO (0) Yes (1)

Have you previously been diagnosed with sleep apnea?.....0 1

If Yes:

When were you diagnosed? Month _____ Year _____

Were you put on CPAP Therapy for treatment? _____

Are you still using your CPAP every night? _____

Total Score:

Note: (Please insert any notes for the doctor regarding snoring, sleep patterns or sleep apnea that you feel may be appropriate use back of pages if necessary.)

PATIENT SIGNATURE: _____ DATE: _____

Office use only:

Advanced screening criteria, if yes to any below, pt should be scheduled for advanced OSA screening.

_____ ESS Score > or = 8? _____ Pt. Eval > or = 2? _____ Subjective Sleep Eval > or = 3? _____

_____ Prior OSA Diagnosis > or = 1?

